AUTHORIZATION

FOR THE DISCLOSURE OF HEALTH INFORMATION TO

THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH,

AIDS DRUG ASSISTANCE PROGRAM

- Federal law requires that the Illinois Department of Public Health (IDPH) AIDS Drug Assistance Program (ADAP) cannot share your health information without your permission except in certain situations. If you sign this form, you are giving ADAP permission to share the health information with the person you indicate below.
- This Authorization will last until the date you specify, or until you tell ADAP you do not want it to share your health information any longer with the person or entity indicated below.
- Right to Revoke: If you decide you do not want ADAP to share your health information any longer, sign the Revocation at the end of this form and give this form to ADAP.
- ADAP (1) cannot refuse payment or deny enrollment or eligibility for benefits if you do not sign this Authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations; and (2) cannot deny treatment if you do not sign this Authorization, unless the treatment and the disclosure are for research purposes; and (3) cannot deny provision of health care if you do not sign this Authorization, unless the provision of the health care is for the purpose of creating health information to share with a third party.
- ADAP cannot promise that the person you permit ADAP to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can contact ADAP to get a copy of this Authorization.

My name: .....

I give permission to the Illinois Department of Public Health, through the AIDS Drug Assistance Program to share my health information checked below with:

.....

- ☐ All of my health information that the ADAP program retains.
- ☐ All of my health information that the ADAP has covering a certain period of time:
  from: ..... to: .....
- ☐ All of my health information that the ADAP has relating to a certain event or injury:
  event or injury: .....
  date of event or injury: .....
- ☐ Other: .....

Purpose: ADAP may share my health information that it has for this purpose:

- ☐ To assist me with my health care.
- ☐ For a research study.
- ☐ Other: .....

Term of Authorization: ADAP may share my health information from the date of this Authorization either until I revoke the Authorization by signing below and giving this form to the Agency, or until this

date: .....

Signature: ..... Date: .....

Signature of Personal Representative: ..... Date: .....

Relationship of Personal Representative: .....

REVOCATION OF AUTHORIZATION

I no longer want ADAP to share my health information with the person indicated above.

Signature: ..... Date: .....